

**APPLICATION FOR RESERVED RESIDENTIAL PARKING FOR PEOPLE WITH DISABILITIES
THE PHILADELPHIA PARKING AUTHORITY
3101 Market Street, Philadelphia, Pennsylvania 19104-2807
(215) 683-9736/683-9809 FAX**

If a parent, guardian or spouse is filling out the application for a child or relative, please list the child or relative as the applicant. (PLEASE PRINT)

Applicant's Name _____

Address (Own _____ Rent _____) _____ Zip Code _____

Telephone _____ Date of Birth _____ Social Security# _____

Occupation, if applicable _____

PLEASE ANSWER THE FOLLOWING QUESTIONS COMPLETELY:

1. What is the nature of your disability?.....
.....
.....

2. Explain why you are in need of reserved parking in front of your home.....
.....
.....

THE ANSWERS TO THE FOLLOWING QUESTIONS WILL BE VERIFIED:

3. Do you have a garage or other off street parking available? (circle one) Yes No

4. Pennsylvania license plate number of the vehicle you use (DV/HP/PD ONLY)

PLEASE ATTACH A PHOTOCOPY OF YOUR VEHICLE REGISTRATION (Displaying address and vehicle information)

5. In whose name is the vehicle registered?.....

6. If the vehicle is not yours, why are you requesting a zone for a vehicle not registered to you? Please be specific.
.....
.....

7. Is your property wide enough to accommodate a 20' long zone? (circle one) Yes No

If the answer to #7 is no, please have your next door neighbor read and complete the consent portion below.

Sign Installation Agreement: I understand that if the front of my home is not 22ft - 25ft from property line to property line, it is my responsibility to obtain the signature of the owner of the adjacent property indicating that they have no objections to the installation of this zone. I further agree that if I use this zone for any purpose other than that which I described in this application, the zone will be removed. I also agree that the Philadelphia Parking Authority retains the right to remove this zone at any time.

CONSENT OF ADJACENT PROPERTY OWNER (Please read carefully if applicable)

I, (print name) _____ certify that I am the owner of (state your address) _____. I understand that my neighbor is in need of additional footage in order to install a reserved parking zone on the street. I have no objections to the City of Philadelphia installing a sign on the sidewalk in front of my property. I am aware that the footage required may be as little as 2ft to a maximum of 15ft depending on the width of my neighbor's home.

Signature _____ Telephone.....

Date _____

A reserved parking space in front of a residence is a special privilege granted by the City of Philadelphia only to people who have severe physical disabilities. Such a space will be granted only to those who are mobility impaired to the extent that they cannot manage without it. These zones will be reviewed at least once every three years.

PHYSICIANS LIST

Please list any or all physicians you wish the City of Philadelphia Health Department and The Philadelphia Parking Authority to contact in order to obtain medical documentation that will support your application for a reserved parking space in front of your home. You must list at least one.

Physician's Name _____ Address.....

City and Zip Code _____ Telephone/FAX.....

Physician's Name _____ Address.....

City and Zip Code _____ Telephone/FAX.....

Physician's Name _____ Address.....

City and Zip Code _____ Telephone/FAX.....

RELEASE OF APPLICANT'S MEDICAL RECORDS

I, _____, residing at _____,
Name Address

hereby authorize the above named medical provider(s) to release my medical records to:

The City of Philadelphia Health Department, The Philadelphia Parking Authority and its affiliated agencies

Signature of Applicant

Date

APPLICANT'S CERTIFICATION

I am aware that it is my responsibility to file a **complete** application. I understand that the application will be returned to me if it is found to be incomplete, illegible, or otherwise not filed in compliance with the instructions. I further agree to submit to an independent examination by a physician from the City of Philadelphia's Department of Health if required.

I certify that the information contained herein is true and correct to the best of my knowledge and belief. I understand that any false statements made herein are subject to the penalties of 18 Pa. C.S. Section 4904, relating to unsworn falsifications to authorities.

Executed on _____ at _____
Date City and State

Signature of Applicant